New Hire Interactive Benefits Guide
Captioning Documents (Transcripts)
For Participating Group Employees

Important: The following document provides the captioning (scripts) of the audio presented in the online New Hire Interactive Benefits Guide. To view the online guide, visit de.gov/statewidebenefits (Select the "**Open Enrollment**" button, choose "Benefits Enrollment for New Hires", then select "Participating Groups").

Table of Contents

Welcome

Welcome to the New Hire Interactive Benefits Guide. The guide uses audio, screen interaction and navigation demos of the Statewide Benefits Office (or SBO) website to help newly hired employees learn about the benefits they are eligible for through the State of Delaware. The guide was created to assist you in being a wise health care consumer when selecting the benefit plans that best meet the needs of you and your family. Learn more about important background information, frequently asked questions and other information by visiting the SBO website at de.gov/statewidebenefits.

Navigation

In order to ease your user experience in this guide, we will first review some of the most important navigation tips. If you would like to skip this navigation information, feel free to click the Main Menu link in the Navigation Panel on the left to access the content of the guide.

Return to Table of Contents

Once the navigation demonstration ends, you will see the Main Menu. From this Main Menu, you will need to select the group that you belong to by clicking on one of the following headers:

- Active State Employees
- Participating Group Employees

Under the header, there is a brief description of the members that belong in the group and a button to access the section of the guide that applies to members of that group. From this page, you can access the Menu button on the top left side of the screen. You can use this Menu button to navigate to all of the benefit information that applies to the group you selected. Notice that the header for any of the screens under the Menu button provides the name for the group that you selected.

Once you have selected an option from the Menu button, you will hear audio and see information on the screen. There are several buttons that will allow you to control what you are viewing and hearing on the screen:

- If you need to, you can view the captioning for the screen that you are viewing by clicking the Captioning tab in the panel on the left.
- The volume button can be used to adjust the volume of the audio or you can use the volume button for your computer or device.
- You can play or pause the information by clicking this button.
- If you want to rewind or fast forward the content, click and drag the progress bar. If you drag it to the left you can rewind the material on the screen and dragging it to the right will fast forward the material.
- If you want to restart the information for the screen that you are viewing, click this button.

Once the progress bar reaches the end for the screen you are viewing, you can learn additional information about the topic by clicking any links that appear on the screen. These links will take you to the SBO website in order to access additional information. If you choose to use the link, the website will open in a separate window - this way you can close that window and easily return to the guide. If you do not want to use the link on the screen, you can use the Menu button to view additional information for your group.

Another helpful feature is the Resource menu. If you click Resources you will see a few web links that allow you to navigate to additional benefit information. There are also takeaway documents for each of the groups that provide the highlights of the information in this interactive guide.

The Navigation panel on the left can be used to quickly navigate through the course. You can simply click the link for the Main Menu or navigate to another section.

There is also a Glossary tab to the left that provides the definition for various benefit-related terms. You can access the Glossary at any time while using this guide.

When you are done viewing information in the guide, simply close the viewing window. The link to the guide will remain on SBO's website.

Main Menu

Participating Group Employees are individuals who are employed by an organization other than the State of Delaware, but his or her employer offers benefits that are provided by the State of Delaware. Some examples of employers in this group include: cities and towns, fire companies, DSWA, DSHA, DTC and UD.

Return to Table of Contents

Welcome to Your Benefits

The State of Delaware, like many employers, faces the challenge of rising health care costs. Expenditures in the State Group Health Insurance Program (GHIP) have risen almost 50 percent since the start of the decade. Employee and pensioner health care was the largest cost driver in the State Operating Budget for Fiscal Year 2016. It is estimated that the State of Delaware's health care costs could exceed $1 billion by Fiscal Year 2023. These costs are growing at a pace that threatens the State's ability to invest in areas important to all of us such as employee and pensioner raises, improving our schools, protecting our environment and making our neighborhoods safer.

The good news is the State of Delaware is committed to managing the total cost of care for both the GHIP and its participants and driving improvements in the health of the GHIP population. In December 2016, the State Employee Benefits Committee (SEBC) formalized this commitment with a strategic framework including specific goals, strategies and tactics to meet those goals. The SEBC mission for the GHIP is to offer State of Delaware employees, retirees and their dependents adequate access to high quality healthcare that produces good outcomes at an affordable cost, promotes healthy lifestyles and helps them be engaged consumers.

It will take a team approach with all of us doing our part as educated health care consumers to control health care costs and ensure high-quality health care remains affordable and sustainable for present and future GHIP members. One very important step you can take is by choosing the right insurance plan that meets the needs of you and your family. Choosing the right plan means understanding your covered benefits, plan design, network providers, comparing costs and making informed decisions. As a new benefit-eligible employee, you are encouraged to actively participate in your new hire enrollment by carefully reviewing the information and tools available to learn more. The enrollment decisions you make now will be effective for the plan year that runs from July 1, 2017 through June 30, 2018 and will remain in effect until the end of the plan year unless you experience a qualifying event such as marriage or birth of a child during this plan year. In May of 2018, benefit-eligible employees will be given a once a year opportunity during Open Enrollment to make changes to their benefits elections for the upcoming plan year.

- Employees will have access to short informational mini-videos on the health plans available to them. Choosing a Highmark or an Aetna health plan is a good choice, but it is important to also know the basics of what each health plan offers. Does the plan require you to meet a deductible before benefits are paid? Is a health reimbursement account available to help you pay for eligible expenses before you meet the deductible or for expenses not paid by the plan? Do you know where to go if you need lab or blood work as each plan has a preferred lab for these services and going to the wrong lab may leave you responsible for the costs? Choosing the HMO plan means that you will pay a lower premium but you must select a PCP (Primary Care Provider) at the time of enrollment for you and any covered dependents that you may need to obtain referrals from your PCP for other services in-network and that you will not have access to out-of-network benefits. Do you know that 98% of State of Delaware members utilize in-network services even in plans where they have the option to go out-of-network for care? Do you know the difference in cost between services obtained in-network versus out-of-network? Do you know what preventive services are covered at no cost?
- Employees will also have access to a brief mini video on the Spousal Coordination of Benefits Policy and how to comply if planning to cover their spouse on their health plan. Failure to complete the form will result in the spouse's coverage being reduced including paying in full for prescriptions at the retail pharmacy.

Return to Table of Contents

Enrollment Action Checklist

The Statewide Benefits Office created an Enrollment Action Checklist to help you navigate the Enrollment process and understand what to do to enroll in your benefit elections.

Select the button on the screen to access a PDF copy of the Enrollment Action Checklist.

Benefits – Health

You have the option to choose from one of four health plans administered by either Highmark Delaware or Aetna. Let's first look at the plans administered by Highmark Delaware. These plans include the First State Basic PPO Plan and the Comprehensive Preferred Provider Organization (PPO) Plan. Both plans are a PPO Plan meaning that there is both in-network and out-of-network coverage and the plans also have plan year deductibles. For example, the First State Basic PPO Plan in-network services have a deductible of $500 per individual and $1,000 per family and then the plan will pay at 90% of the Highmark Delaware allowable charge.

The Comprehensive Preferred Provider Organization (PPO) Plan also has in- and out-of-network coverage. However, by using in-network services, you will pay only a small copay or coinsurance with no deductible. More than 98% of services State of Delaware members seek are in-network, but you have the added benefit of out-of-network services, if needed, subject to a plan year deductible.

Learn more about what the Highmark Delaware plans cover and what the costs are, by visiting the SBO website at de.gov/statewidebenefits. Select the "Benefit Programs" button, then choose "Health." To determine the monthly premium for each of the health plans, refer to the Rate Sheet effective July 1, 2017. On the Highmark Delaware page, you can view the Summary of Benefits and Coverage (or SBC) for the First State Basic PPO Plan and the Comprehensive PPO Plan. On this link, you can also access Highmark Delaware's website, find a health provider and more.

Let's now look at the plans administered by Aetna. These plans include the Aetna CDH Gold Plan with an HRA and the HMO Plan. The Aetna Consumer Directed Health (CDH) Plan with a Health Reimbursement Account (HRA) is a PPO Plan with an in-network plan year deductible of $1,500 per individual and $3,000 per family. There is also a fund of $1,250 per individual and $2,500 per family to help cover your eligible health expenses. Here is how it works - each year, the State funds the health reimbursement account (HRA) - the fund - for you so that you can use the fund dollars to pay eligible out-of-pocket health care costs including the costs for services you receive before you reach the deductible. This means that you have less to pay out of your own pocket. Once you meet your in-network deductible, your health plan pays at 90% of the Aetna allowable charge. If you don't use all of your fund dollars in one year, unused amounts will roll over to the next plan year as long as you remain in the CDH Gold Plan.

The Aetna HMO Plan is an in-network only plan but includes both a local and broader national network so it is important to make sure the doctors and hospitals you use can accept the Aetna HMO coverage before you enroll. There is no out-of-network coverage under this plan which means that you will be 100% responsible for the cost of any services you receive from a provider or hospital that is not in the Aetna HMO network. Members in this plan are also required to select a Primary Care Physician (PCP) upon enrollment. Members who do not select a PCP upon enrollment will be automatically assigned one by Aetna. Members can find PCPs and Provider numbers by using Aetna's DocFind website. Members always have the flexibility to change their PCP at any time simply by contacting Aetna.

Return to Table of Contents

Choosing a PCP is essential as your PCP will assist in managing and coordinating your care. Referrals are required for certain services and are obtained through your PCP.

Learn more about what the Aetna plans cover and what the costs are, by visiting the SBO website at de.gov/statewidebenefits. Select the "Benefit Programs" button, then choose "Health." To determine the monthly premium for each of the health plans, refer to the Rate Sheet effective July 1, 2017. On the Aetna page, you can view the Summary of Benefits and Coverage (or SBC) for the HMO Plan and CDH Gold Plan. Check out the FAQs to learn how the CDH Gold Plan works. On this link, you can also access Aetna's website and mobile app, find a health provider using DocFind and more.

It is also important to note that most preventive care is covered at 100% for all health plans. The list of preventive services covered by Highmark Delaware or Aetna can be found on the Consumerism Resource Link at de.gov/healthconsumer by selecting Learn More under "Prevention Saves."

Benefits – Prescription

When you enroll in a State of Delaware health care plan, you are automatically enrolled in the prescription drug plan managed by Express Scripts. **The Spousal Coordination of Benefits (SCOB) policy also applies to prescription coverage.**

The State of Delaware list of covered medications (also known as the preferred formulary) contains guidelines that can assist you with managing your prescriptions, identifying generics and choosing the most effective medications at the most reasonable price. Please note the formulary may change periodically as Express Scripts reviews and updates the plan's list of covered medications each year.

The amount you pay as your share of the cost for a prescription drug will vary depending on the specific medication and the number of days prescribed. The co-payment is different for Tier 1 Generic, Tier 2 Preferred Brand and Tier 3 Non-preferred Brand drugs.

Generic Drugs are approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, a generic drug works the same as a brand-name drug and usually costs less.

Your Express Scripts plan includes a Generic vs. Brand Medications Choice Program, which allows you to purchase a brand medication when a generic equivalent is available; however, you will pay the generic copay plus the cost difference between the generic and the brand medication.

If there is a medical reason why you cannot take the generic equivalent, you, your doctor or your pharmacist may initiate a coverage review to allow you to obtain the brand name drug at the non-preferred copay. These authorizations are effective for a one year period, and must be submitted for renewal annually.

The Express Scripts Prescription plan includes several member cost saving programs such as:
The **Maintenance Medication Program**, under which members fill 90-day prescriptions for maintenance medications for only 2 times the 30-day retail co-payment. All 90-day prescriptions for non-specialty maintenance medications can be filled at any participating retail pharmacy or through Express Scripts Home Delivery. **Please note**: (1) You are required to fill certain long-term medications using 90-day fills

or you will pay a penalty copay (see the Maintenance Medication Program information for more details). (2) Not all medications are available in a 90-day supply.

Under the **Preventive Medication & Services** program, members may receive certain preventive medications at no cost through the Express Scripts prescription drug plan, subject to age and other limitations. To obtain these preventive medications at no cost, the member must present a doctor's prescription for the medication to a participating Express Scripts pharmacy, even if the medication is available over the counter (OTC).

Under the **Diabetic Program**, members may obtain diabetic supplies (lancets, test strips, syringes/needles) at a participating retail pharmacy, a 90-day participating retail pharmacy, or through the Express Scripts Pharmacy (mail order) at no cost. Multiple prescriptions for diabetic medications provided via Express Scripts at a 90-day participating retail pharmacy or the Express Scripts Pharmacy and *purchased at the same time* may be obtained for one copay.

Did you know that you can choose **Retail or Home Delivery**? Members may fill prescriptions for up to a 90-day supply of medication at any 90-day participating retail pharmacy or through Express Scripts Home Delivery, via the Express Scripts Pharmacy. Shipping is free and you can request refills by phone or online at Express-Scripts.com. To get started, mail the prescription, a completed mail-order form, and payment to Express Scripts Pharmacy, or ask your doctor to fax the prescription to Express Scripts Pharmacy by calling 1-888-327-9791 for instructions.

The **Coverage Review Programs** ensure you are receiving prescription medications that result in appropriate, cost-effective care. Examples include Step Therapy where certain medications may not be covered unless you have first tried another medication or therapy; Preferred Specialty Management which uses prior authorization and step therapy to ensure that you are taking the most clinically appropriate, cost-effective medication first; and quantity rules that are in place for many medications including narcotics and other controlled substances to comply with Federal Food and Drug Administration guidelines. In these examples, Express Scripts will need to review additional information from your doctor before a decision is made if the prescription medication can be filled under your plan.

For more information, contact Express Scripts Customer Service 24 hours a day, 7 days a week, toll-free at-1-800-939-2142. Pharmacists are available around the clock.

The Prescription Drug Plan Frequently Asked Questions (FAQ) provides answers to the most commonly asked questions about the Express Scripts Prescription Drug Plan.

More detailed Express Scripts Prescription Drug Plan information can be found online on the Statewide Benefits Office website at de.gov/statewidebenefits. Select the "Benefit Programs" button, then choose "Prescription."

If you have general questions about your prescription drug benefits, please contact the Statewide Benefits Office Customer Service Team by phone at (302) 739-8331 or (800) 489-8933, or by email at benefits@state.de.us.

Benefits – Dela*WELL* Health Management Program

All of your health and wellness programs, services and information come from one source - your trusted health plan carrier! Enrolling in a State of Delaware Group Health Plan provided by Highmark Delaware

or Aetna gives you automatic, confidential access to their online resources, a 24/7 nurse line, health coaching, online health assessments and disease management programs. A licensed professional Health Coach may call if you have a health condition to offer you services to better manage your health. You are encouraged to take the call as what you learn could make a real difference in improving your health.

The greatest wealth is having your health! There are no cash incentives in the 2017-2018 Dela*WELL* Program Year; however, the State of Delaware encourages you to focus on the things that really matter like leading a happy and healthy life. In addition, participation in the Dela*WELL* Health Management Program is an effective way to help manage long-term health care costs for you and for the State of Delaware.

The State of Delaware is encouraging members who are enrolled in either a non-Medicare Highmark Delaware Plan or Aetna Plan to complete these two simple steps:

1. Schedule and attend your Annual Physical Exam - Most preventive care is covered 100% (no charge to you). Your doctor (Internal Medicine, General Practitioners, Family Practice and GYNs) can provide annual physicals, as well as treat small problems before they become serious. During a routine physical, your doctor can measure things like your height, weight and blood pressure, review your health history and make sure you are up to date with your age-appropriate screenings. A regular exam is a great way to help strengthen your doctor-patient relationship.
2. Complete your online Health Assessment (Wellness Profile) - It is a simple online survey, located on the Highmark Delaware and Aetna websites, which helps you understand where you stand with your health and provides an action plan and recommendations that can help you to maintain or improve your well-being. When completing your online Health Assessment, be sure to have your latest biometric numbers handy from your annual physical exam, as it will ask for this information.

For additional information on the Dela*WELL* Health Management Program and the services and programs offered through Highmark Delaware and Aetna, visit the SBO website at de.gov/statewidebenefits. Select the "Benefit Programs" button, then choose the button for "Dela*WELL* Health Management." Here you will find information on gym and wellness discounts, health resources, frequently asked questions, an annual physical exam checklist, tracking sheet and doctor memo and the wellness and disease management benefits provided through the health carriers.

Benefits – Dental

Delta Dental and Dominion National administer the State's dental programs. It is important to note that enrollment in these plans is a binding election. This means that you may not change this election unless you experience a qualifying event.

The Delta Dental PPO Plus Premier Plan allows you to see any dentist you choose and receive applicable benefits. You can choose a dentist from the Delta Dental Premier network, the Delta Dental PPO network or a dentist who does not participate with Delta Dental. However, you'll maximize your savings if you see a dentist who participates with Delta Dental. This is because dentists who participate in Delta Dental's network cannot charge you more than the allowed amount for covered services. However, non-participating dentists can bill you for an amount that is greater than the allowed amount set by Delta Dental for covered services. If a non-participating dentist charges more than the allowed amount, you are responsible for paying the difference. It is also important to note that payments for services by a network dentist are paid directly to that dentist by Delta Dental. If you see an out-of-

network dentist, you will need to pay the dentist and Delta Dental will send you a check for the cost of the service up to the allowed amount. Delta Dental payments vary by service, based on Delta Dental's schedule of allowed amounts for its networks. Your annual reimbursement maximum is $1,500 per plan year per participant. Additional information about the Delta Dental Plan can be found on the SBO website at de.gov/statewidebenefits. Select the "Benefit Programs" button, choose "Dental", then select "Delta Dental." On this page, you can access the contact information for Delta Dental, view the PPO highlights, read Frequently Asked Questions, learn how to get the most from your plan and access dental health and wellness resources.

The Dominion National plan provides you the choice of any participating dentist in the **Select Plan** network. If you choose to enroll in the Dominion National plan make sure *before* you enroll that your dentist participates in the Select Plan network by viewing the provider listing found on the Dominion National website. You cannot change plans or drop coverage during the plan year if your dentist decides to no longer participate in the plan. If your dentist decides to no longer participate in the plan, your only option is to select a different dentist from the provider listing.

The Dominion National plan provides limited costs, fixed fees and low premiums. It is important to note that you will need to pay a $10 office visit copayment for your cleaning at the time of service. But, for each member who gets their two cleanings during the plan year and completes a survey, Delta Dental will reimburse you $20. Additional information about the Dominion National Plan can be found on the SBO website at de.gov/statewidebenefits. Select the "Benefit Programs" button, choose "Dental", then select "Dominion National." On this page, you can access the contact information for Dominion National, view the description of benefits, member copayments and dentist directory, learn how to take advantage of the reimbursement through the prevention rewards program and view a helpful enrollment video.

Here are the dental plan rates effective July 1, 2017:

These rates are located on the SBO website at de.gov/statewidebenefits. Select the "Benefit Programs" button, then choose "Dental".

Please note that it is up to each participating group whether or not to offer State sponsored Dental plans. Please contact your Human Resources/Benefits Office to verify the dental plan options available to you.

Benefits – Employee Assistance Program (EAP) + Work/Life

The experts at your confidential EAP+Work/Life program, administered by HMS (Health Advocate), can find resources to help you get more balance in your life. HMS is available seven days a week, 24 hours a day to meet all of your needs.

Work/Life:
- Balancing Work & Family
- Time Management
- Working with Others
- Occupational Stress
- Career Development

Return to Table of Contents

- Workplace Safety/Productivity

Personal Well-Being:
- Anxiety; Depression; Substance Abuse
- Relationships; Family/Parenting
- Stress Management; Grief and Loss

Living Resources:
- Financial Help; Legal Assistance
- Childcare; Adult Care

The EAP+Work/Life program is available exclusively for State of Delaware Group Health Plan Members and their dependents, including parents and parents-in-law.

As part of your employee benefit plan, you have access to a wide range of EAP+Work/Life support services from HMS (Health Advocate), including Professional Counseling Services, Legal Services, Interactive Website and much more.

Your EAP+Work/Life program, paid for by the State of Delaware, is completely confidential. Additional information about the EAP+Work/Life Program can be found on the SBO website at de.gov/statewidebenefits. Select the "Benefit Programs" button, then choose "EAP+Work/Life." On this page, you can access the HMS (Health Advocate) website and phone number, view a list of available services, read HMS newsletters and view a short video to help you get to know the program.

Benefits – Blood Bank

Blood Bank of Delmarva is a 501(c)3 non-profit, community service program that provides blood and blood products for hospitals in the Delmarva region. More than 350 blood donors are needed every day to meet the needs of patients at those hospitals.

Each year, in our community, over 20,000 patients need blood or a blood product. By joining Members for Life, you are showing your support for this valuable community service and helping to ensure a stable blood supply for everyone in our community. Also, each time you give, you not only save lives, but you earn rewards and benefits.

View additional information about Blood Bank of Delmarva Members for Life program on the SBO website at de.gov/statewidebenefits. Select the "Benefit Programs" button, then choose "Blood Bank." On this page, you can access the Blood Bank of Delmarva's website and blood donation sites, schedule a blood donation appointment, learn more about the blood bank and how to join Members for Life:

Joining is easy! Donate blood at least once a year and allow the Blood Bank to contact you when there is a need for your blood type.

Participating Group Employees interested in participating in Members for Life can create an account directly with the Blood Bank of Delmarva online at www.delmarvablood.org.

Under Helpful Resources, you can review donation requirements, learn how to become an organ and tissue donor and check out Blood Bank news and events.

Return to Table of Contents

Coordination of Benefits – Spousal

The Spousal Coordination of Benefits Policy states that generally, if your spouse is employed full-time or retired from another employer that offers health insurance and is responsible for 50 percent or less of the monthly premium for the lowest health benefit plan available, he or she is required to enroll through his or her employer's coverage as primary. When a benefit-eligible State of Delaware employee is married to a benefit-eligible Participating Group Employee, both members must enroll in separate coverage with his or her own employer. Neither member can be enrolled in more than one State Group Health Insurance Plan*.

If you cover your spouse in one of the State of Delaware's Group Health Insurance medical plans, you MUST complete a Spousal Coordination of Benefits form upon initial enrollment, each year during your Open Enrollment period, and anytime your spouse's employment or insurance status changes. If an employee and spouse both are benefit-eligible State of Delaware employees, the spouse who carries the benefits MUST complete a new Spousal Coordination of Benefits form each year during Open Enrollment. When completing the form, make sure to indicate in the Spouse Information section that your spouse is a benefit-eligible State of Delaware employee.

The Spousal Coordination of Benefits Form is used to determine a spouse's eligibility to receive primary coverage in a State of Delaware Group Health Insurance plan and to certify if the spouse has other health care coverage available through his or her employer or former employer. You will be contacted if additional documentation regarding your spouse's coverage is required. Failure to complete the Spousal Coordination of Benefits Form or provide additional documentation when required will result in a reduction of spousal benefits.

Information about the Spousal Coordination of Benefits Policy, along with other helpful information, can be found on the SBO website at de.gov/statewidebenefits. Once on the site, select the "Coordination of Benefits" button. Here you will find:

- The Spousal Coordination of Benefits Policy
- Information on accessing the Spousal Coordination of Benefits Electronic Form
- A chart with examples showing which plan is primary (or pays first) when active or retired State of Delaware Group Health Insurance Plan members and spouses have more than one health care coverage
- Important information if your spouse's employer offers a High Deductible Health Plan with a Health Savings Account

If you have questions about the Spousal Coordination of Benefits policy or the form, please contact the Statewide Benefits Office at 1-800-489-8933 or benefits@state.de.us from 8:00 a.m. to 4:30 p.m. Monday through Friday.

Coordination of Benefits – Dependent

The Dependent Coordination of Benefits Policy states Active State of Delaware employees and Participating Group employees enrolled in a non-Medicare health care insurance plan under the State Group Health Insurance Program (GHIP), may cover their dependent children to age 26 in their State health care plan, dental plan and/or vision plan with no restriction on marital, employment, student,

resident or tax status. Pursuant to the Group Health Insurance Program Eligibility and Enrollment Rules, an employee's children are defined as sons, daughters, stepchildren and adopted children.

The Dependent Coordination of Benefits Form is required in accordance with the Group Health Insurance Program Eligibility and Enrollment Rules. Dependent Coordination of Benefits forms must be completed for each enrolled dependent regardless of age, upon:

- Enrollment in other health coverage,
- Any time other health coverage changes, or
- Upon request by the Statewide Benefits Office, Highmark Delaware or Aetna.

In other words, the Dependent Coordination of Benefits Form only needs to be completed for dependent children – not spouses. And, it does not need to be completed if your child only has coverage through the State GHIP.

Information about the Dependent Coordination of Benefits Policy can be found on the SBO website at de.gov/statewidebenefits by selecting the "Coordination of Benefits" button. Under Forms and Documentation you will find:

- The Dependent Coordination of Benefits Policy
- The Dependent Coordination of Benefits Frequently Asked Questions (FAQ), which provides answers to the most commonly asked questions pertaining to Dependent Coordination of Benefits
- The Highmark Delaware Dependent Coordination of Benefits Form
- The Aetna Dependent Child Coordination of Benefits Form
- A helpful chart with examples showing which plan is primary (or pays first) when a dependent child has more than one health care coverage

If you have questions about the Dependent Coordination of Benefits policy or the form, please contact the Statewide Benefits Office at 1-800-489-8933 or benefits@state.de.us from 8:00 a.m. to 4:30 p.m. Monday through Friday.

Policies

Important policies and procedures are located on the SBO website at de.gov/statewidebenefits. Select the "Policies & Procedures" button.

Here you will find information on:

- Spousal & Dependent Child Coordination of Benefits
- Qualifying Events
- And more…

If you have questions about the policies and procedures, please contact the Statewide Benefits Office at 1-800-489-8933 or benefits@state.de.us from 8:00 a.m. to 4:30 p.m. Monday through Friday.

Return to Table of Contents

Notices

Health care coverage notices and other important information are located on the SBO website at de.gov/statewidebenefits. Select the "Policies & Procedures" button, then choose "Group Health Insurance Program (GHIP) Notices.

These notices relate to the State of Delaware Group Health Insurance Program (also known as the GHIP) and are effective as of March 1, 2017.

Questions regarding these notices can be addressed to the Statewide Benefits Office at 1-800-489-8933 or at benefits@state.de.us from 8:00 a.m. to 4:30 p.m. Monday through Friday, or questions may be directed to the additional contacts identified in the various notices.